

NOTIFICATION OF MEDICAID TRANSPORTATION DENIAL

HEALTH DEPARTMENT

Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_ Medicaid ID Number: \_\_\_\_\_

Recipient Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is to notify you that the transportation you requested to

\_\_\_\_\_ on \_\_\_\_\_  
Name of Provider Date

has been denied because of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Date

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

If you do not agree with this denial, you have the right to appeal to the Virginia Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, Virginia 23219. The appeal must be made within 30 days of the receipt of this notice. Forms for making an appeal will be provided by the local health department, the local social services department, or by the Virginia Department of Medical Assistance Services.